

**KENTUCKY BOARD OF DENTISTRY
FACILITY INSPECTION FOR GENERAL ANESTHESIA**

This page is to be completed by dentist prior to inspection.

Street Address _____

City and Zip _____

Phone # _____

Personnel

*Include all dentists using facility
Use additional sheets if necessary*

*This column to be completed by
inspector.*

Dentist _____ License No. _____

☐

Anesthesia Assistant _____

☐

Dentist _____ License No. _____

☐

Anesthesia Assistant _____

☐

Dentist _____ License No. _____

☐

Anesthesia Assistant _____

☐

Dentist _____ License No. _____

☐

Anesthesia Assistant _____

☐

Dentist _____ License No. _____

☐

Anesthesia Assistant _____

☐

To be completed by inspector

Inspected by _____

Date _____

☐ Inspection complete & satisfactory

☐ Inspection is incomplete, will send proof of missing items to board office.

☐ Inspection is incomplete and requires re-inspection.

GENERAL ANESTHESIA INSPECTION LIST

	<u>Yes</u>	<u>No</u>
A. Operatory & Recovery Room		
1. Minimum size of Operatory room 10 ft. x 8 ft. or 80 sq. ft.	<input type="checkbox"/>	<input type="checkbox"/>
2. Minimum door or egress from Operatory room 36 in. net, or evidence EMS Gurney can be brought into room	<input type="checkbox"/>	<input type="checkbox"/>
3. Minimum size of recovery room if present 8ft. x 4ft. or 32 sq. ft.	<input type="checkbox"/>	<input type="checkbox"/>
4. Minimum door or egress from recovery room 36 in. net or evidence EMS gurney can be brought into room	<input type="checkbox"/>	<input type="checkbox"/>
5. Minimum hallway from Operatory room to exit 42 in. width net	<input type="checkbox"/>	<input type="checkbox"/>
B. Equipment		
1. Oxygen Systems		
Primary with positive pressure	<input type="checkbox"/>	<input type="checkbox"/>
Secondary portable oxygen	<input type="checkbox"/>	<input type="checkbox"/>
2. Suction System		
Primary	<input type="checkbox"/>	<input type="checkbox"/>
Secondary portable (non electric, unless back-up generator available)	<input type="checkbox"/>	<input type="checkbox"/>
3. Operating Light		
Primary	<input type="checkbox"/>	<input type="checkbox"/>
Secondary surgical lighting or portable non-electric	<input type="checkbox"/>	<input type="checkbox"/>
4. Operating chair/table with flat position	<input type="checkbox"/>	<input type="checkbox"/>
C. Monitoring & Emergency Equipment		
1. Stethoscope	<input type="checkbox"/>	<input type="checkbox"/>
2. Sphygmomanometer	<input type="checkbox"/>	<input type="checkbox"/>
3. Pulse Oximeter	<input type="checkbox"/>	<input type="checkbox"/>
4. Oral Airway - Small, Medium, Large	<input type="checkbox"/>	<input type="checkbox"/>
5. Face Mask - Small, Medium, Large	<input type="checkbox"/>	<input type="checkbox"/>
6. I.V. access equipment	<input type="checkbox"/>	<input type="checkbox"/>
7. I.V. Fluids	<input type="checkbox"/>	<input type="checkbox"/>
8. Cardiac Monitor	<input type="checkbox"/>	<input type="checkbox"/>
9. Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
10. Laryngoscope/Blades – Small, Medium, Large	<input type="checkbox"/>	<input type="checkbox"/>
11. Endotracheal Tubes	<input type="checkbox"/>	<input type="checkbox"/>
D. Emergency Drugs		
1. Nitroglycerin Spray or Ointment	<input type="checkbox"/>	<input type="checkbox"/>
2. Vasopressor - Name _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Antihypertensive – Nitroglycerin recommended (Procardia not recommended)	<input type="checkbox"/>	<input type="checkbox"/>
4. Narcan Narcotic Antagonist	<input type="checkbox"/>	<input type="checkbox"/>
5. 50% Dextrose	<input type="checkbox"/>	<input type="checkbox"/>
6. Antihistamine – Name _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Aerosol Bronchodilator	<input type="checkbox"/>	<input type="checkbox"/>
8. Anticonvulsant – Valium recommended	<input type="checkbox"/>	<input type="checkbox"/>
9. Epinephrine	<input type="checkbox"/>	<input type="checkbox"/>
10. Atropine	<input type="checkbox"/>	<input type="checkbox"/>
11. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
12. Romazicon	<input type="checkbox"/>	<input type="checkbox"/>
13. Lidocaine HCl (I.V. Use)	<input type="checkbox"/>	<input type="checkbox"/>
14. Succinylcholine	<input type="checkbox"/>	<input type="checkbox"/>
E. Records		
1. Patient medical history form	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient anesthesia record	<input type="checkbox"/>	<input type="checkbox"/>
3. Office narcotic and scheduled drug record	<input type="checkbox"/>	<input type="checkbox"/>
F. Personnel		
1. Chair-side assistant with current CPR	<input type="checkbox"/>	<input type="checkbox"/>